

DOTD TRANSITIONAL DUTY PLAN

Employee Name: _____

Dist/Sect. _____ Title: _____

Supervisor: _____

Effective Date of Transitional Plan: _____

Work Location: _____

Gang/Section (if different): _____

Work Schedule: _____

Supervisor: _____

Tasks to be performed while on transitional duty:

Modifications/accommodations: _____

EMPLOYEE PORTION

I, _____, hereby certify that this Transitional Duty Plan has been discussed with me. I further understand that failure to abide by this plan may result in disciplinary action as stated in Civil Service Rules.

My signature below indicates that I agree to return to work under the terms and conditions of this plan.

Employee Signature

Date

Appointing Authority Signature

Date